STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150018	A. BUILDING 00 B. WING	08/04/2011

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S0000	The visit was for a licensure survey. Facility Number: 005017 Survey Date: 08-01-11 to 08-04-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Karilyn Tretter, RN Public Health Nurse Surveyor QA: claughlin 08/17/11	S0000		
S0102	410 IAC 15-1.2-1 (a) (a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules. Based on personnel file review, facility policy and procedure review, and staff interview, the facility failed to ensure the employment of personnel in accordance with state rule IC 16-28-13-4 for 3 of 3 nursing assistant/mental health technician personnel files reviewed (P5, P6 and P7).	S0102	Human Resources contacted The Indiana State Home Health Aide/Nurse Aide Registry to obtain information on how to conduct a home health aide/nurse aide registry check. Proper information was obtained and beginning August 4, 2011 all newly hired, non-licensed, direct patient care positions as specified	08/24/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings: 1. At 8:45 AM on 8/3/11, review of IC 16-28-13-4 indicated that: a. "Except as provided in subsection (b), a person who: (1) operates or administers a health care facility; or (2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility; shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3 or another source by law." 2. at 2:30 PM on 8/2/11, review of personnel files indicated: a. staff member P5 was a nursing assistant hired 3/14/11 who was lacking documentation of a check of the home health aide/nurse aide registry check b. staff member P6 was a nursing assistant hired 3/22/11 who was lacking documentation of a check of the home health aide/nurse aide registry check c. staff member P7 was a mental health technician hired 5/10/10 who was lacking documentation of a check of the home health aide/nurse aide registry check		in their job description will require a home health aide/nurse aide registry check as part of the "Prospective Employee Screening" process (policy #HR-78-revised policy attached). Human Resources Policy #HR-26 titled "License/Certification Validation" has been revised to include "all newly hired non-licensed personnel who would be performing hands-on patient care as specified in their job description, will be required to be checked through the Indiana State Home Health Aide/Nurse Aide Registry." (attached) In addition to the above, an active employee list of non-licensed personnel who perform hands-on patient care as specified in their job description was generated and a home health aide/nurse aide registry check was conducted and filed in their personnel record. The list of non-licensed, direct patient care positions as specified in their job descriptions was given to the Human Resources Recruitment Staff in order that the home health aide/nurse aide registry check will be conducted as part of the "Prospective Employee Screening". The home health aide/nurse aide registry check was added to the "New Hire Check-list" which is an internal form used by recruitment staff to indicate what specific checks are required as indicated in HR policy	

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	d. staff members P5, P6 and P7 were unlicensed personnel working in a nurse aide capacity 3. at 9:00 AM on 8/2/11, review of the facility policy "Prospective Employee Screening", with a policy number of "HR-78", and a last review date of 1/10, indicated: a. under "Points of Emphasis", it reads: "To insure that all employees who provide direct patient care are appropriately screened." 4. interview with staff members NG and NK at 4:00 PM on 8/2/11 and 8:45 AM on 8/3/11 indicated: a. these staff members were unaware that the nurse aide registry needed to be checked for newly hired nursing assistants, as per IC 16-28-13-4 b. the policy HR-78 lacks any language indicating the state nurse aide registry is to be checked for newly hired, unlicensed staff, who would be performing hands on patient care duties, as a nurse aide might do		#HR-78 titled “Prospective Employee Screening” and HR policy #HR-26 titled “License/Certification Validation”. The Human Resources Department is responsible for ensuring compliance.	

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S0284	410 IAC 15-1.4-1 (b)(3) (b) The governing board is responsible for the conduct of the medical staff. The governing board shall do the following: (3) Ensure that the medical staff has approved bylaws and rules and that the bylaws and rules are reviewed and approved at least triennially. Governing board approval of medical staff bylaws and rules shall not be unreasonably withheld.			
	Based on medical record review and policy/procedure review, the facility failed to ensure that the medical staff was operating under current bylaws, rules and regulations approved by the governing board in 1 (P2) of 4 medical records. Findings include: 1. Medical record review on 8/3/2011 indicated that P2 was discharged/died on 2/4/2011. The Discharge Summary for P2 was dictated on 3/14/2011. 2. Review of the Elkhart General Hospital Medical Staff Rules and Regulations on 8/4/2011 indicated on Page 5 of 7 under XIV. THE DISCHARGE SUMMARY "...A discharge summary/final note must be completed within 7 days of patient discharge."	S0284	**Health Information Management will remind/educate the medical staff on this rule requiring the Discharge Summary to be completed within 7 days of discharge/death. Complete date: 9/15/11** **Health Information Management will do a follow up audit after education to assure compliance with current medical staff bylaws and rules. If additional issues are found, this matter will be forward to the medical staff for resolution. Complete date: 11/15/11**	09/15/2011

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S0312	410 IAC 15-1.4-1(c)(6)(D) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on personnel file review, policy and procedure review, and staff interview, the governing board failed to ensure that an evaluation was performed for 1 contracted dialysis registered nurse (P1). Findings: 1. at 8:45 AM on 8/3/11, review of the policy and procedure "Employee Performance Review Program..." with a number "HR-41" and a last reviewed date of 01/10, indicated: a. under "Procedure/Instructions", it reads in item 1. "Frequency of Reviews. Employees shall be reviewed when one of the following occur: a. annually, toward the end of each calendar year..." 2. at 2:30 PM on 8/2/11, review of 2 contracted dialysis RN (registered nurse)	S0312	Contracted dialysis RN's P1 and P2 have had evaluations completed by EGH staff and submitted to Fresenius our dialysis contractor (see Exhibit 1 – S312 for updated evaluation forms entitled "Evaluation of Contract Service Staff"). The process to assure complete files for contract service staff is now established and is outlined in policy NA-44 "Contract Service Staff (Noncredentialed) and Traveling Nurses." (see Exhibit 2 – S 312). The Human Resources Department is responsible for ensuring compliance.	08/25/2011

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	personnel files indicated: a. P1 first worked at the facility on 9/01 and most recently worked 7/29/11 and was lacking a performance evaluation provided by this facility b. P2 first worked at the facility on 2/11 and most recently worked on 8/2/11 3. interview with staff member NG at 9:00 AM on 8/3/11 indicated: a. 90 day evaluations may be done with new staff, but policy indicates an annual review is mandatory b. staff member P2 is not due for an annual eval c. staff member P1 had evaluations by the contracted agency, but lacked any indication the facility had input into the evaluation or performed an evaluation of their own for this employee who has worked at the facility since 2001			
S0554	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.			
	Based on observation and interview, the facility failed to minimize infection exposure and risk to health care workers and patients in the housekeeping laundry	S0554	1,2,3. Cart storage areas for separate parking of clean and soiled linen carts outside of traffic. Resolution – 2 carts have been identified for soiled mops and soiled cleaning cloths and	08/25/2011

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	area of the department. Findings: 1. The American Institute of Architects (2001) guidelines for hospitals, Section 7.23, subheading B3 indicates the following; Cart storage area(s) for separate parking of clean- and soiled-linen carts out of traffic. 2. During a facility tour on 08-02-2011 at 0957 hours, an open cart containing bags of soiled housekeeping mop heads and cleaning cloths was observed in the hallway outside of the entrance to the main housekeping storage area. 3. During an interview on 08-04-2011 at 0945 hours, employee #A9 confirmed the cart was placed outside of the housekeeping department for the convenience of the housekeeping staff when bringing bags of soiled materials to the department for laundering. 4. The American Institute of Architects (2001) guidelines for hospitals, Section 7.23, subheading D5 indicates the following; Arrangement of equipment that will permit an orderly work flow and minimize cross-traffic that might mix clean and soiled operations. 5. During a facility tour on 08-02-2011 at		are now placed in the room by the washing machine inside of the room and away from traffic. 4,5,6. Arrangement of equipment that will permit an orderly flow and minimize cross – traffic that might mix clean and soiled operations. Resolution – a). All clean materials ie: paper products, liners, books and clean laundered mops and cleaning cloths are now stored in the small separate room to the right as you enter our main housekeeping storage area. The cleaning cloths and mops are housed in covered barrels. Resolution – b). All soiled mops and cleaning cloths are now in carts sitting beside the washer in the large main room; no carts are in the hall. All other remaining housekeeping items are also stored in an orderly fashion in this large main area. Environmental Services is responsible for ensuring compliance. The deficient areas/issues identified are now being monitored on a weekly basis and included in the QA reports provided to Administration and HHA.	

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	1000 hours, an observation in the main housekeeping storage area was made of a commercial washer and a cart containing bags of soiled housekeeping materials next to open barrels where clean mop heads and microfiber cleaning cloths were being stored. 6. During an interview on 08-02-2011 at 1000 hours, the staff person present in the department (employee #A10) confirmed that the soiled linens were stored next to the clean materials by the washing machine until they were laundered.			
S0594	410 IAC 15-1.5-2(f)(3)(D)(ii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (ii) Universal precautions, including infectious waste management. Based on policy/procedure review and observation, the facility failed to ensure that their policy on infectious waste was being followed.	S0594	Biohazard signs for the Critical Care and PACU soiled utility rooms were installed on 8/4/2011. Also, a housewide audit was conducted to make	08/04/2011

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	Findings include: 1. Review of Hospital Policy IFC-29 "Release of Pathological Waste" on 8/4/2011 includes, on Page 1 of 2, under Containment: 1. "All persons and facilities subject to this rule shall ensure that infectious waste is at all times contained in a manner that will reasonably protect...from contracting dangerous communicable disease that may result from exposure to the infectious waste" and 2. "All persons and facilities subject to this rule shall place pathological waste in containers that are": d. "Labeled with the biohazard symbol." 2. During hospital tour of CCU (Critical Care Unit) on 8/2/2011, a red Biohazard bag and box were found in the Soiled Utility room and there was no Biohazard sign on the door. 3. During hospital tour of PACU (Post-Anesthesia Care Unit) on 8/3/2011, a red Biohazard bag and box were found in the Soiled Utility room and there was no Biohazard sign on the door.		sure biohazard signage is posted appropriately throughout.Plant Operations is responsible for ensuring compliance. Biohazard signage will be monitored during our monthly Facility/Safety rounds, which are condcuted by a multi-disciplinary Administrative Team.	

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S0598	410 IAC 15-1.5-2(f)(3)(D)(iv) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iv) Aseptic technique, invasive procedures, and equipment usage. Based on observation, policy and procedure review, and staff interview, the facility failed to implement its policy related to aseptic technique in relation to the changing of surgical masks between cases for 4 staff observed, in relation to hair not covered by the bouffant cap for 1 staff member, and in relation to earrings not covered by the bouffant cap for 1 staff member. Findings: 1. at 2:25 PM on 8/1/11, review of the policy and procedure "Attire: Semi-Restricted and Restricted Area of OR"(operating room) , Policy number Aa-6, with a last revision date of 2/10, indicated: a. under "Points of Emphasis", it reads in item 8. "All persons entering the	S0598	Hospital "Surgical Attire Policy" revised to reflect mask are to be disgarded after every case and if **s**oiled. Masks are not to be worn hanging around neck or kept in pockets. OR staff and anesthesiology providers will be re-educated on surgical attire policy. Monitoring of hair and jewelry being covered and proper use of masks will be done. The Surgery Department, which reports to the DON over Surgery, is responsible for ensuring compliance. The surgery supervisor for each shift will daily monitor the surgical attire policy is being followed. If the policy is not being followed, they will report it to the department Manager or Director. The Manager /Director will meet with the individual to correct the issue.	08/22/2011

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	"restricted" areas of the OR...will wear a mask..Masks will be changed BETWEEN cases or when it becomes soiled or wet." b. under "Points of Emphasis", it reads in item 9. "All surgical services staff wearing jewelry must meet the following requirements: Earrings and necklaces must be confined by surgical attire (scrubs and hair coverings)..." c. under "Points of Emphasis", it reads in item 10. "Hospital approved head coverings must be worn...ALL hair must be confined within the head covering." 2. at 10:30 AM on 8/3/11, while on tour of the surgery area in the company of staff members NL, NN, and NO, it was observed that: a. one OR assistant was in the "inner core" and later noted in an OR suite, with a patient present, with earrings not covered by the head covering/bouffant headwear b. staff member NO had neckline hair not confined within the surgical head covering c. staff member NO carried the surgical mask in the breast pocket of their scrub top d. in OR suite #10, it was noted that one staff member was preparing the room for a case and had the surgical mask dangling about the neck			

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	3. at 9:45 AM on 8/4/11, while reviewing medical records at the CCU (cardiac/constant care unit), in the company of staff member NP, it was noted that two surgical staff were walking about the facility with surgical masks in the back hip pockets of their scrubs 4. at 9:50 AM on 8/4/11, staff member NP approached the two staff (mentioned in 3. above), an anesthesiologist and a student, and mentioned that new masks were to be used for each surgical case. The anesthesiologist expressed surprise at this knowledge and stated that they were not aware of the policy			
S1104	410 IAC 15-1.5-8(a)(1)(A)(B) (a) The hospital shall be constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for services authorized under the hospital license as follows: (1) The plant operations and maintenance service, equipment maintenance, and the environmental service shall be: (A) staffed to meet the scope of the services provided; and (B) under the direction of a person or persons qualified by education, training, or experience. Based on observation and staff interview,	S1104	**#3** The hyperthermia cart is checked by Pharmacy to manage	08/24/2011

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	the facility failed to ensure the safety of patients in regard to the possibility of an error in results of lab tests due to expired lab tubes, hemocult results due to expired slides and other expired products in 3 areas toured (Oncology in patient unit, AIC --ambulatory infusion center, and Obstetrics). Findings: 1. at 10:20 AM on 8/2/11, while on tour of the Oncology in patient nursing unit in the company of staff members NC and NF, it was observed in one area: a. 9 Hemocult testing cards that expired 7/11 b. 3 BD Porta Cul specimen tubes that expired 8/19/10 and one that expired 3/23/11 2. at 11:00 AM on 8/2/11, while on tour of the AIC in the company of staff members NC and NF, it was observed in the storage room that: a. >50 blue top lab tubes expired 7/11 b. >10 red top lab tubes expired 5/11 3. at 1:45 PM on 8/3/11, while on tour of the surgery and recovery area of the obstetrics nursing unit in the company of staff members NP, NQ, NR and NS, that: a. in the Malignant Hyperthermia kit was one ARROW brand Central Venous Cath Kit that expired 2/11		the medication inventory and outdate. The mix up occurred between the surgery anesthesia tech and the surgery educator, each thinking the other was checking the cart. The surgery anesthesia tech checks the surgery hyperthermia cart. She has now taken on the maternity hyperthermia cart and a check log has been placed on top of the cart to record the daily checks. **See attached (UPDATED) Policy M15 – Malignant Hyperthermia Crisis Management Policy, in which the green highlighted section addresses how this will be monitored and who is responsible for ensuring compliance.**#1 & #2 For OCS we will no longer be stocking the anaerobic vials on the unit. Instead, we will call when we need one. For AIC we have cleaned out the filing cabinet where the outdated vials were found so it's clear what is being used or not used. See attached Lab Outdates form. This has been posted in both units where the lab tubings are stocked. The staff assigned to restock these items each week are also instructed to check all items for outdates and date/initial this form. The Manager of Oncology & AIC is responsible for ensuring compliance and will monitor by reviewing the posted forms for	

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	b. in a small tray/basket on the nursing counter were 2 Kendal Monoject 3/10 syringes that expired 9/09 c. in a small tray/basket on the nursing counter was one Kendal 1 cc syringe that expired 7/09 4. interview with staff member NA at 12:45 PM on 8/4/11 indicated: a. there is no "formal" facility policy/procedure related to nursing unit routine checks for out dated supplies b. it is "up to the manager" for each unit to "develop a process" for checking the expiration dates of various supplies on their specific nursing unit c. none of the nursing units toured have such a unit specific policy related to checking supplies routinely		correct & up to date information.	
S1164	410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review, thermolabile indicator testing, and staff interview, the	S1164	Nutrition Services records dishmachine temperatures three times per day at the following	08/04/2011

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	150018	A. BUILDING 00 B. WING	08/04/2011

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	facility failed to ensure preventive maintenance was properly performed on the kitchen dishwasher. Findings included: 1. In review on 8/02/2011 at 12:30 pm, the Retail Food Establishment Sanitation Requirements 410 IAC 7-24-303 read, "(b) After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: ... (2) hot water mechanical operations by being cycled through equipment that is set up as specified under section 283, 285, or 286 of this rule and achieving a utensil surface temperature of one hundred sixty (160) degrees Fahrenheit as measured by an irreversible registering temperature indicator;" 2. On 8/02/2011 at 12:00 pm, the surveyor requested the dishwasher operator to stick the thermolabile indicator on a plate and run thru the equipment to check the wash and rinse cycle temperature. When the plate came out the other end, the indicator label did not change color or turn black as to be expected. The test was again performed and the indicator still did not change color which meant the required temperature for the wash and rinse cycle were not achieved. At this		times: 7 am, 12 pm, and 7 pm. Minimum temperature standards for the department are as follows: Wash 155 degrees, Rinse 160 degrees, and Final Rinse at 180 degrees. Corrective action is recorded for any area below the recommended minimum temperature standard. Corrective action includes the following: sending an internal engineering workorder and/or contacting Hobart for a service repair call.On 8/2/2011, state health surveyors, Janelli and Albert, conducted a temperature test on the dishmachine around 1 pm and discovered that the final rinse temperature was below the recommended temperature of 180 degrees. They conducted a second test to verify it was not working at which point it was shut down until repaired. Nutrition Services was not asked to present documentation of temperatures. Nutrition Services indicated to both inspectors that Hobart was out the previous night, 8/1/2011, for a scheduled repair on the temperature thermostat for the rinse dial. Paperwork was provided for documented repair. Hobart before leaving that night did not indicate it wasn't working properly. On 8/1/2011, we recorded the following final rinse temps: 7 am – 190, 12 pm – 188, and 7 pm – 190 degrees. That morning, 8/2/2011, we recorded a temperature of 185 degrees	

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	point, the surveyors told the operators to stop using the dishwasher for washing plates and silverwares and instead use disposables. 3. On 8/02/2011 at 3:00 pm, review of preventive maintenance (PM) and service records for the dishwaher indicated that monthly PM was performed by an independent company. The last was done 6/13/2011 and indicated the final rinse was "Not Functioning Properly" and the reading for the final rinse temp (temperature) was "200 deg F". F=Fahrenheit. Note: The required final rinse temperature per 410 IAC 7-24-285 read, ""...in a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may be not more than one hundred ninety-four (194) degrees Fahrenheit..." Futher review of PM records indicated final rinse problems on 4/10/2011 and 4/08/2011. Service was performed by another company and indicated problems with the dishwasher on almost a monthly basis: 7/14/2011; 7/10/2011; 6/02/2011; 5/16/2011; 3/22/2011; 2/08/2011; and 1/04/2011. 4. In interview on 8/02/2011 at 12:30 pm, when asked for the dishwasher temperature monitoring records, staff member #J1 indicated that not such log		which met the required minimum temperature, however, during the inspection; we discovered it was not holding at the required temperature. Hobart was immediately called back out that day in which a technician arrived in the afternoon. Another technician arrived the following day, 8/3/2011, to repair the machine. On 8/4/2011, state surveyor, Brian Montgomery, conducted a test on the dishmachine in which the minimum temperature was above 180 degrees. Nutrition Services did not renew the service maintenance agreement for 2011. It was deemed unnecessary to maintain the function of the dishmachine. Nutrition Services is currently reviewing the need to replace the current dishmachine which is 13 years old, or repair and renew the service agreement with Hobart. Dishmachine is currently operating at required temperature standards per the State guidelines. Temperature documentation for the past three years can be provided upon request. Nutrition Services is responsible for ensuring compliance. Temperatures are recorded by the Supervisors three times a day and monitored by the Director. The logs & any actionable items will be reported quarterly to the Infection Control Committee.	

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	was available to review as PM was performed by the independent company. There was no evidence that the facility validated the temperature readings obtained by the independent company.			
S1186	410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E) (i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities. Based on observation and staff interview, the safety committee and the facility failed to ensure the safety of patients related to the possibility of burns from heated blankets in one unit toured. (Obstetrics) Findings: 1. at 1:15 PM on 8/3/11, while on tour of the Obstetrics nursing unit in the company of staff members NP, NQ, NR and NS, it was observed in a storage room in the "North Pod", that the	S1186	**S1186 #1,2,3** We have several combination blanket / fluid warmers in the hospital located in the surgery areas. Practice is to record the temperatures twice daily with specified temperature limits. The warmers were new to OB with the location of the surgical suite to the area. Staff were noting the temp on the digital readout as practice, but not recording it. Even though surgery	08/26/2011

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	Getinge blanket warming cabinet had a temperature reading of 161 degrees (after the cabinet door was opened, the temperature read at 156 degrees) 2. interview with staff members NP, NQ, NR and NS at 1:20 PM indicated: a. it was unknown what the appropriate/safe temperature was to be, per the manufacturer's guidelines b. there is no policy/procedure related to staff members checking the warming cabinet temperature routinely, as is done with medication and food refrigerators, etc. 3. review of the Getinge warming cabinet user manual at 1:00 PM on 8/4/11 indicated: a. on page 2-5 there is a "warning" symbol with a note that reads: "BURN HAZARD. Items heated to over 49 degrees C (120 degrees F) can burn skin. Keep items that may contact skin at temperatures below 49 degrees C (120 degrees F)." 4. interview with staff members NA, NP and NT at 1:05 PM on 8/4/11 indicated: a. it is thought that the warming cabinets are set at a high level (160 degrees) so that blankets will be appropriately warmed for patient comfort b. no staff routinely check the temperature status of warming cabinets to assure patient safety related to possible burns from too warm blankets c. there is no policy related to blanket warmers/cabinets and nothing that relates to maximum temperatures allowed, as per manufacturer's recommendations, or a facility decision to determine a higher temperature is approved or allowed		is recording the temperatures twice daily, no policy existed to guide the practice in all 3 surgery areas, main OR, OB OR and CVOR. Attached is a policy and log forms which have been implemented and are in place now. **AORN was used as the reference for this policy.** Please see the attached UPDATED S1186 Policy which states it is the responsibility of the manager where the warming unit is located to assure the temperature readings are performed and recorded on the log.	